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Antipsychiatry Revisited: Toward Greater Clarity

A friend reported to me the other day that she was at a conference with other "progressive professionals" in which her colleagues kept passing questionable judgments on antipsychiatry positions and theorists, this on the basis of fallacious beliefs. Indeed, one of the colleagues in question stated as if it were a matter of fact that all antipsychiatry activists were right wing, then proceeded to cite as an example thereof an activist who is neither right wing nor antipsychiatry. By the same token, over the last decade, people have commonly made statements to me of the ilk, "What bugs me about antipsychiatry people is they only care about tearing down; there is no commitment to actually helping people." All of which suggests that there is a serious dearth of awareness about antipsychiatry, the range of its adherents, and what they stand for. This is minimally unfortunate. It impedes our working together. What is likewise relevant, with psychiatry's power and capacity to harm continuing to grow by leaps and bounds, the antipsychiatry message has never been so important as it is today. This being the case, over the last few years, I have taken upon myself the task of attempting to dispel confusions and to promote clarity.

In other publications, I have focused broadly, providing overall accounts of antipsychiatry (see Burstow 2014a and b). My intent in this piece is considerably more modest. It is to respond in abbreviated form to some very specific confusions/misconceptions surrounding antipsychiatry. I am drawing in this regard on the myth/fact distinction—a helpful heuristic, despite its obvious shortcomings.

Myths/Facts

Myth: Antipsychiatry theorists deny or minimize the enormity of the personal/emotional distress into which people can sink.
Fact: While no doubt some so minimize, they are decidedly in the minority. It goes without saying that people can end up in truly abysmal states, and like many who coalesce on this territory, antipsychiatry folk are deeply concerned about the welfare of people in distress. What is being maintained, rather, is that emotional difficulties and confusion are not in themselves "diseases" and hence should not be approached as such. In this regard, antipsychiatry theorists oppose the medicalization of problems in living. Additionally, they draw a sharp distinction between two phenomena that are routinely conflated—being distressed oneself (which may or may not be something for which services are needed/wanted) and being found distressing by others (which can often be traced to societal intolerance or unawareness).

Myth: Antipsychiatry activists have no interest in people receiving the help which they need.
Fact: As people who care deeply about those in distress, antipsychiatry activists commonly lobby for increased services, albeit the commodification of help which is

part and parcel of the concept services is something they challenge. More broadly speaking, we strive to co-create a society which is less “distressing” in the first place, wherein everyone has ready access to an abundance of help, moreover, where people in distress are reached out to. What we oppose is “psychiatric treatment” (pseudo-medicine, which is inherently harmful) on the one hand and coercion and manipulation on the other—as distinguished from genuine help which people are truly free to accept or refuse.

Myth: Antipsychiatry activists are anti-drug.
Fact: While some of us have a critique of medicine overall, antipsychiatry activists see a legitimate place for the medical use of drugs (drugs which address *bone fide medical conditions*). Many of us would additionally decriminalize street drugs. Moreover, we recognize and respect that since time immemorial people have coped with the use of substances which, as it were, “take the edge off”, that allow people who are floundering for any number of reasons to get through the day. What we are against is the “medical” pushing and the prescribing of pseudo-medicine on one hand, and the government support for and legitimation of such substances and practices on the other.

Myth: Antipsychiatry theorists oppose professional services.
Fact. While antipsychiatry theorists reject psychiatry and commonly critique other disciplines, there is no uniform rejection of other disciplines (except in insofar as they have become colonized by psychiatry). More concretely, besides that antipsychiatry advocates have often joined forces with others in lobbying for more non-medical services (e.g., supportive house, drop-ins, befriending services), there are antipsychiatry activists who are themselves practicing social workers and practicing psychologists. This notwithstanding, as people with a vision of a very different kind of society, the vast majority of antipsychiatry theorists oppose the wholesale transferring of human help into the hands of experts, whatever those experts may be called, and would prioritize instead more organic and more community-based services. Correspondingly, many hold a Foucauldian analysis of disciplinary regimes.

Myth: Antipsychiatry theorists are all right-wingers.
Fact: Class analysis is not one of the bases of unity among antipsychiatry advocates. As a consequence, there are antipsychiatry advocates on the left (e.g., Don Weitz), and antipsychiatry advocates on the right (e.g., Thomas Szasz). Who predominates? The left, the anarchistic, the feminist, the gay and trans positivist, and the anti-racist.

Myth: Antipsychiatry theorists are all followers of R. D. Laing.
Fact: The name “antipsychiatry” originated with Laing’s colleague Cooper (1967). This notwithstanding, the meaning of antipsychiatry has shifted over the years to one of psychiatry abolition. Of these abolitionists, some are influenced by Laing, while others are not, with the latter in the majority. Nonetheless, while rejecting his use of terms like “schizophrenia”, all would agree that society is deeply implicated in the seemingly individual angst that people feel. And by the same token, all would agree that the current targeting of individuals as “the problem” is woefully off base.

Myth: If I am critical of psychiatry, then I am antipsychiatry.
Fact: While all antipsychiatry theorists are *critical of psychiatry*, not all such critics are *antipsychiatry*. The difference is that in the absence of an abolitionist stance, one is not antipsychiatry.

Myth: Antipsychiatry folk look down on people who take psychiatric drugs.

Fact: Antipsychiatry folk take a position on the drugs and their "pushers", in essence on the institution—not on the people who use these substances. It is generally understood and accepted that people cope as best they can, often very heroically, under less than ideal circumstances.

Myth: Antipsychiatry activists only work with activists and thinkers who are likewise antipsychiatry.
Fact: Most actively participate in broad-based coalitions. Correspondingly, they put on conferences with others in the community. And they routinely include non-abolitionists in their publications and themselves contribute to publications theorized from alternate perspectives (in this last regard, note the large number of antipsychiatry contributors—e.g., Weitz, Burstow, Diamond, and Starkman—to the mad politics book *Mad Matters*, edited by LeFrançois, Menzies, and Reaume, 2013).

Myth: Antipsychiatry theorists are hyper-critical of families.
Fact: This misconception stems largely from the ongoing conflation between antipsychiatry and R. D. Laing (who again is at most peripheral in current antipsychiatry). Laing saw family dynamics as pivotal to the emotional distress in which people find themselves, much as psychoanalysts do. In the process, while some of his analyses were highly insightful, he could without question also be blatantly unfair to family members—mothers in particular (see, for example, Laing and Esterson, 1970)—none of which, note, has any bearing on antipsychiatry. The point is, while individuals vary, antipsychiatry per se has *no position* on the family. That said, where one or more family member has been subjected to psychiatry, insofar as there is a tendency among theorists, it would be to see the family as a whole as a victim of psychiatry, however that psychiatrization came about and whether or not cooptation was involved. What is likewise relevant, in the world for which antipsychiatry activists strive, there would be far more support (read: noncompulsory and non-pathologizing support) available to families in distress.

Myth: To be antipsychiatry is to be a follower of Thomas Szasz.
Fact: At this juncture, it would be hard, if not impossible, to be an antipsychiatry theorist without being substantially influenced by Szasz. And indeed, to date Szasz remains the most pivotal figure. Obvious influences include rejecting the notion of mental illness and seeing the psychiatrist as an agent of state control. Being a "follower", however, is a separate matter altogether. Besides that the very idea of being a follower runs counter to how most antipsychiatry activists operate, while respecting the foundational works of Thomas Szasz, most antipsychiatry activists have substantial differences with him. Difference include: Unlike Szasz, few are right wing. Unlike Szasz, more or less none see prisons as any kind of solution (in this regard, we are more influenced by Foucault, 1995 than Szasz). Unlike Szasz, most have a strong commitment to transformative justice. And what is absolutely pivotal, all by definition are abolitionists, whereas despite his foundational critique, strictly speaking, Szasz himself was not an abolitionist (see in this regard, Szasz, 1961 and Szasz, 2009).

Myth: Antipsychiatry folk are all ivory tower intellectuals.
Fact: This is at once factually and interpretively incorrect. While academics for sure figure in antipsychiatry circles, it is survivors, whether academic or otherwise, who constitute the majority and indeed the core. Correspondingly, few of the academics could be depicted as "ivory tower". More generally, people from all walks of life gravitate toward and find a base and a home in the antipsychiatry community. These include: survivors, activists, professionals, academics, artists, family members—and a subsection that is getting larger by the moment—every day people who began with

no such politic but found themselves on a steep learning curve having lost family members and/or loved ones to psychiatry.

Myth: To be antipsychiatry is to be unreasonable and impractical.
Fact: On an individual basis, antipsychiatry folk, like everyone else, can be reasonable or unreasonable, practical or impractical. The antipsychiatry mandate, on the other hand, (working to phase out an institution that is serving us poorly and constitutes a threat to everyone), on the face of it, is eminently reasonable. By contrast, positions predicated on continuing to tinker with psychiatry, when, arguably, such positions have themselves contributed to the current state of affairs, are minimally questionable.

Myth: Antipsychiatry folk think that all psychiatrists are bad and deny that some people are helped by their psychiatrists.
Fact: Antipsychiatry theorizing operates on a very different level. It is a position on an institution—not a position on *individuals*. Advocates in no way deny that some people may be helped by their psychiatrist, just as some are helped by their priests. What antipsychiatry is maintaining rather is that psychiatry's fundamental tenets and practices are insupportable—both epistemologically and morally.

Myth: Antipsychiatry theorists oppose all psychiatric reform.
Fact: Antipsychiatry theorists hold that reform can never be sufficient for the paradigms and tenets of psychiatry are faulty. What goes along with this, they see reform as having a tendency, irrespective of intent, to reinforce the status quo. As such, it would be fair to say antipsychiatry does not focus on reform and in no way can be seen as reformist. This notwithstanding, as with most revolutionary movements, being antipsychiatry inevitably also involves supporting more limited agendas, this, while keeping an eye on the larger goal. Which? And how are such choices made? Here once again there is no unanimity. Some antipsychiatry organizations support only those initiatives related to increased rights for psychiatric survivors. Some would prioritize support for initiatives around homelessness, others, safety. Correspondingly, those who employ the attrition model as a guide (see Burstow, 2014c) make decisions based on the answer to the question: If successful, will the actions or campaigns that we are considering move us closer to the long range goal of psychiatry abolition? What is likewise significant, a distinction must be made between "not actively supporting" and "opposing". Antipsychiatry activists seldom oppose reforms that on the surface seem benign. The point is, as with everyone else, our assessment can be wrong, and regardless, we are not in the business of undermining our allies. However, we may or may not endorse or support such initiatives, and where we do not, once again, generally it because we see them in the long run as running counter to the abolitionist agenda, as re-entrenching psychiatry, or more worrisome still, helping it expand.

Myth: Antipsychiatry would deny people the right to protect themselves against "violent others".
Fact: An antipsychiaty position in no way involves denying that people can be violent or opposing protective measures. Rather, it involves opposing measures based on the assumption that the people deemed "mad" tend to be violent—for statistics show that the "mad" are no more violent than anyone one else. Correspondingly, it involves opposing solutions that are inherently incarceral, controlling, individualizing, pathologizing, harmful, and otherwise oppressive.

Myth: To be antipsychiatry is to be anti-choice.
Fact: Herein lies an ever recurring and profound confusion. The confusion is not limited to antipsychiatry. It also extends to psychiatry and to the nature of choice

itself. From a radical vantage point, it is institutional psychiatry that is in the business of depriving people of choice—not antipsychiatry. What goes along with this, to theorize choice in the context of harm, of underlying intrusion, of artificial options, of rampant misinformation, and of ruling institutional agendas, is to fall into a liberal notion of choice (for elaboration, see Burstow 2014d). What is likewise relevant, antipsychiatry activists are working toward the creation of a society wherein people have considerably more choices, correspondingly, where services arise organically from felt needs and desires—not from the vicissitudes of industry profit.

Myth: If antipsychiatry activists had their way, everyone who uses psychiatric drugs would soon find themselves robbed of their life line.
Fact: No abolitionist would find it acceptable for anyone to be put in such straits—irrespective of their position on these substances.

Myth: Antipsychiatry theorists ignore what history teaches us—that if we rid ourselves of psychiatry, some other tyranny would take its place.
Fact: Antipsychiatry theorists are well aware of the history of madness—and of how one type of oppressor succeeded another. We focus on psychiatry because for centuries now, it has been in charge of the "madness turf, moreover because it has expanded that terrain in unprecedented ways. At the same time, as people who do not see any form of tyranny as acceptable, nor tyranny itself as inevitable, we work toward the creation of a more egalitarian and caring society (in particular, see Burstow, 2015, Chapter Nine—in press).

Myth: Antipsychiatry activists are stuck in the past.
Fact: Besides that a case could be made that antipsychiatry has never been so relevant and so pressing as it is today, paradoxically, the problem is in in some ways the opposite of what is expressed above. That is, while antipsychiatry is rooted in a vision for the future, to varying degrees, when thinking about change (and I in no way am denying that some of our allies here are highly progressive), most folk have difficulty thinking very far beyond the present—hence the paradigmatic reformist position. As a result, they keep falling into what institutional ethnographers like Smith (2005 and 2006) call "institutional capture". What antipsychiatry activists are doing, in essence, is inviting people to think further, to see beyond the structures and conceptions that are now taken as "givens", and dare to entertain a radically different, more humane, more accepting, more respectful, and more relational way of operating.